SECTION 2
CMS-1500 CLAIM FILING INSTRUCTIONS

The CMS-1500 claim form should be legibly printed by hand or electronically. It may be duplicated if the copy is legible. Medicaid paper claims should be mailed to:

Infocrossing Healthcare Services, Inc.
P.O. Box 5600
Jefferson City, MO 65102

Information about ordering claim forms and provider labels is in Section 3 of the Medicaid *Providers Manual* available at **www.dss.mo.gov/dms**.

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

Field number and name		Instructions for completion
1.	Type of Health Insurance Coverage	Show the type of health insurance coverage applicable to this claim by checking the appropriate box. For example, if a Medicare claim is being filed, check the Medicare box, if a Medicaid claim is being filed, check the Medicaid box and if the patient has both Medicare and Medicaid, check both boxes.
1a.*	Insured's I.D.	Enter the patient's eight-digit Medicaid or MC+ ID number (DCN) as shown on the patient's ID card.
2.*	Patient's Name	Enter last name, first name, middle initial *in this order* as it appears on the ID card.
3.	Patient's Birth Date Sex	Enter month, day, and year of birth. Mark appropriate box.
4.**	Insured's Name	If there is individual or group insurance besides Medicaid, enter the name of the primary policyholder. If this field is completed, also complete fields 6, 7, 11, and 13. If no private insurance is involved, leave blank.
5.	Patient's Address	Enter address and telephone number if available.

Field number and name		**Instructions for completion**
6.**	Patient's Relationship to Insured	Mark appropriate box if there is other insurance. If no private insurance is involved, leave blank.
7.**	Insured's Address	Enter the primary policyholder's address; enter policy-holder's telephone number, if available. If no private insurance is involved, leave blank.
8.	Patient Status	Not required.
9.**	Other Insured's Name	If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name. If no private insurance is involved, leave blank. [See Note (1)]
9a.**	Other Insured's Policy or Group Number	Enter the secondary policyholder's insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. If no private insurance is involved, leave blank. [See Note (1)]
9b.**	Other Insured's Date of Birth	Enter the secondary policyholder's date of birth and mark the appropriate box reflecting the sex of the secondary policyholder. If no private insurance is involved, leave blank. [See Note (1)]
9c.**	Employer's Name	Enter the secondary policyholder's employer's name. If no private insurance is involved, leave blank. [See Note (1)]
9d.**	Insurance Plan	Enter the secondary policyholder's insurance plan name. If no private insurance is involved, leave blank. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* [See Note (1)]

Field number and name	Instructions for completion
10a.-10c.** Is Condition Related to:	If services on the claim are related to patient's employment, an auto accident or other accident, mark the appropriate box. *If the services are not related to an accident, leave blank.* [See Note (1)]
10d. Reserved for Local Use	May be used for comments/descriptions.
11.** Insured's Policy or Group Number	Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. If no private insurance is involved, leave blank. [See Note (1)]
11a.** Insured's Date of Birth	Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. If no private insurance is involved, leave blank. [See Note (1)]
11b.** Employer's Name	Enter the primary policyholder's employer name. If no private insurance is involved, leave blank. [See Note (1)]
11c.** Insurance Plan Name	Enter the primary policyholder's insurance plan name. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* [See Note (1)]
11d.** Other Health Plan	Indicate whether the patient has a secondary health insurance plan. If so, complete fields 9-9d with the secondary insurance information. [See Note (1)]
12. Patient's Signature	Leave blank.
13. Insured's Signature	This field should be completed only when the patient has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the

Field number and name		**Instructions for completion**
		provider of Medicaid. Payment may otherwise be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder.
14.**	Date of Current Illness, Injury or Pregnancy	This field is required when billing global prenatal and delivery services. The date should reflect the last menstrual period (LMP).
15.	Date Same/Similar Illness	Leave blank.
16.	Dates Patient Unable to Work	Leave blank.
17.**	Name of Referring Physician or Other Source	Enter the name of the referring physician. If the physician is nonparticipating in the Missouri Medicaid Program, enter “nonparticipating.” *This field is required for independent laboratories and independent radiology groups (provider types 70 and 71), and providers with a specialty of “30” (radiology/radiation therapy).*
17a.**	I.D. Number of Referring Physician	Enter the referring physician’s Medicaid provider number. If the physician is nonparticipating in the Missouri Medicaid Program, enter “nonparticipating.” *This field is required for independent laboratories and independent radiology groups (provider types 70 and 71), and providers with a specialty of “30” (radiology/radiation therapy).*
18.**	Hospitalization Dates	If the services on the claim were provided in an in-patient hospital setting, enter the admit and discharge dates. If the patient is still in the hospital at the time of filing, write “still” in the discharge date field or show the last date of in-patient service that is being billed in field 24a. This field is required when the service is performed on an in-patient basis.
19.	Reserved for Local Use	Providers may use this field for additional remarks/descriptions.

Field number and name	Instructions for completion
20.** Lab Work Performed Outside Office	If billing for laboratory charges, mark the appropriate box. The referring physician may **not** bill for lab work that was referred out.
21.* Diagnosis	Enter the complete ICD-9-CM diagnosis code(s). Enter the primary diagnosis as No. 1, the secondary diagnosis as No. 2, etc.
22.** Medicaid Resubmission	For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.
23. Prior Authorization Number	Leave blank**.**
24a.* Date of Service	Enter the date of service under “from” in month/day/year format, using a six-digit format. All line items **must** have a from date. A “to” date of service is required when billing on a single line for subsequent physician hospital visits on consecutive days.
24b.* Place of Service	Enter the appropriate place of service code. See Section 15.8 of the Medicaid *Physician’s Provider Manual* for the list of appropriate place of service codes.
24c. Type of Service	Leave blank.
24d.* Procedure Code	Enter the appropriate CPT or HCPCS code and applicable modifier(s), if any, corresponding to the service rendered. (Field 19 may be used for remarks or descriptions.) See Section 6 of this booklet for a list of modifiers used by the Missouri Medicaid program.
24e.* Diagnosis Code	Enter 1, 2, 3, 4 or the actual diagnosis code(s) from field 21.

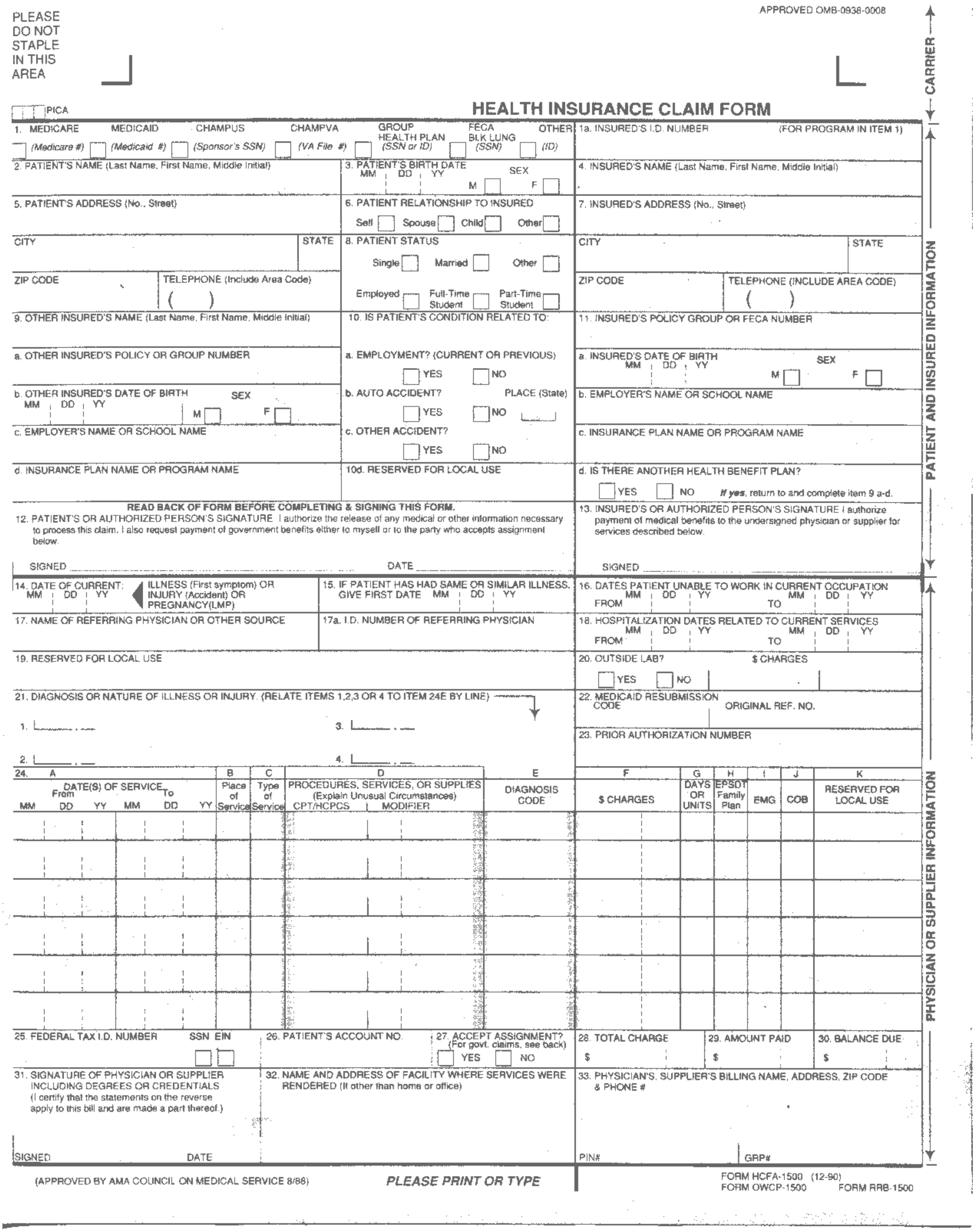
Field number and name	Instructions for completion
24f.* Charges	Enter the provider's usual and customary charge for each line item. This should be the total charge if multiple days or units are shown.
24g.* Days or Units	Enter the number of days or units of service provided for each detail line. The system automatically plugs a "1" if the field is left blank. Anesthesia—Enter the total number of minutes of anesthesia. Consecutive visits—Subsequent hospital visits may be billed on one line if they occur on consecutive days. The days/units must reflect the total number of days shown in field 24a. Injections—Only for those providers not billing on the Pharmacy Claim form. Enter multiple increments of the listed quantity administered. For example, if the listed quantity on the injection list is 2 cc and 4 cc are given, the quantity listed in this field is "2."
24h.** EPSDT/Family Planning	If the service is an EPSDT/HCY screening service or referral, enter "E." If the service is family planning related, enter "FP." If the service is both an EPSDT/HCY and Family Planning service enter "B."
24i. Emergency	Leave blank.
24j. COB	Leave blank.
24k.** Performing Provider Number	This field is required only for a clinic (group practice), FQHC, public health agency, teaching institution or independent radiology group. Enter the Missouri Medicaid provider number of the physician or other professional who performed the service.
25. SS#/Fed. Tax ID	Leave blank.
26. Patient Account Number	For the provider's own information, a maximum of 12 alpha and/or numeric characters may be entered here.
27. Assignment	Not required on Medicaid claims.

Field number and name		**Instructions for completion**
28.*	Total Charge	Enter the sum of the line item charges.
29.**	Amount Paid	Enter the total amount received by all other insurance resources. **Previous Medicaid payments, Medicare payments, cost sharing and co-pay amounts are not to be entered in this field.**
30.	Balance Due	Enter the difference between the total charge (field 28) and the insurance amount paid (field 29).
31.	Provider Signature	Not Required.
32.**	Name and Address of Facility	If the services were rendered in a facility other than the home or office, enter the name and location of the facility. This field is required when the place of service is other than home or office.
33.*	Provider Name/ Number /Address	Affix the provider label or write or type the information **exactly** as it appears on the label.

* These fields are mandatory on all CMS-1500 claim form.

** These fields are mandatory only in specific situations, as described.

(1) NOTE: This field is for private insurance information only. If no private insurance is involved **leave blank**. If Medicare, Medicaid, employers name or other information appears in this field, the claim will deny. See Section 5 of the Medicaid *Provider's Manual* for further TPL (Third Party Liability) information.



PLEASE
DO NOT
STAPLE
IN THIS
AREA

APPROVED OMB-0938-0008

CARRIER

☐☐ PICA

HEALTH INSURANCE CLAIM FORM

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____________ DATE ____________

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____________

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ___ . ___
2. ___ . ___
3. ___ . ___
4. ___ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500